NCSI Treatment Summary

User guide and template

Background

GPs reported a multiplicity of information from secondary care but the lack of a simple summary of the patients' cancer diagnosis, treatment and ongoing management plan. Clinic letters failed to provide sufficient information to enable patients to be fully managed in the community resulting in unnecessary delays and referrals back to secondary care.

In 2009 a group of Macmillan GPs identified information that would be helpful at the end of initial treatment. To capture this information a Treatment Summary (TS) template was designed. The TS is for use at the end of primary treatment for cancer e.g. at the end of surgery and/or adjuvant therapy with details added to the TS related to endocrine treatment or other maintenance treatment. The TS may also be used when there is a referral from secondary care to palliative care for symptom control rather than the cancer treatment. The information will be helpful to the GP in supporting the patient and carers. The TS may also be useful at other points in the journey e.g. following treatment for recurrence.

The TS replaces the standard clinic letter and provides the patient and their GP with the details of the care and treatment received and any support they may require in the future and therefore improves communications.

The TS has been tested in secondary care communities across several tumour groups, using a variety of methodologies. In 2010 approximately 250 summaries were issued to GPs over a 6 month period. Its use was evaluated via surveys, telephone interviews and face to face meetings with over 50 clinicians. An updated version of the TS based on this learning has been developed for wider use. There are no copyright issues so feel free to adapt the format to suit your local community or IT systems.

Audience:

The TS is aimed at:

- General Practitioners and primary care professionals.
- The patient, to enable greater understanding and clarity of their condition and provide a summary to share with others of their choice e.g. for travel insurance purposes.
- Secondary care clinicians, particularly in A&E and for unplanned emergency admissions.
- Hospices, day centres and care homes.

Presentation style and format

During testing the majority of test sites used the template and boxes in the format provided; others converted to a letter template to improve ease of use by secretarial staff. Some sites created electronic versions using an access database with a series of drop down menus to aid the speed of completion. One site transmitted the TS electronically to the GP, others printed and posted. One consultant used the TS in place of all the routine clinic letters and provided a copy for the patient to take with them when leaving the clinic.

Depending on local practice there are three presentation styles you may wish to consider, the standard form/template (appendix 1), a letter template (appendix 2) or an electronic solution (appendix 4).

The electronic solution template is available on the Cancer Information Systems (CIS) for Somerset Cancer Register and InfoFlex CIMS Ltd. This system enables the template to be populated from the patient's electronic record and therefore reduces the amount of input required from the clinician at the end of treatment. For further information or to develop this idea contact your CIS provider.

Treatment Summary templates

The Treatment Summary template has been revised since testing to remove the less useful information and simplify it.

- Appendix 1 provides the simplified TS template with updated GP READ codes.
- Appendix 2 provides the same information in a letter template.
- Appendix 3 provides a completed example template with prompt notes.
- Appendix 4 provides an example screen shot from the Somerset Cancer Register.
- Appendix 5 provides a user guide with rational for data inclusion and an indication of the essential and desirable fields required should local re-design of the form be required.

Recommended practice

The following standards support the ongoing use of the TS.

- All sections of the TS should be completed and a copy given to the patient and sent the GP promptly at the end of primary treatment for cancer.
- TS updates should also be generated at key points e.g. following recurrence, further treatment or a transition to end of life care.
- The TS should not replace a detailed care plan based on an assessment of need
- All members of the MDT involved in the patients care should have the opportunity to contribute to the completion of the TS.
- The GP should enter the details onto their data base and use the information to inform the Cancer Care Review. http://www.ncsi.org.uk/what-we-are-doing/assessment-care-planning/cancer-care-review/

- GPs should ensure the patient is entered onto appropriate monitoring, screening programme and review surveillance systems if required e.g. osteoporosis.

Hints and tips to consider for implementation:

The following hints and tips have been provided by the NHS Improvement test sites:

- Engage administrative staff early in the change process and encourage them to suggest the best way to implement locally.
- Ensure that the medical records department are familiar with the Treatment Summary and are aware of the appropriate place in the notes for filing (this will avoid them being removed from the patient's records inappropriately).
- If the TS template is redesigned to fit with other hospital documents beware of removing data inclusions/fields as they may be useful to others. See rationale for data fields and inclusion on the Treatment Summary in **Appendix 5**.
- Provide a laminated prompt list in clinic for clinicians to use as they dictate.
- Create template letter with headings to enable easier typing.
- Always use the TS in place of a clinic letter at the end of initial treatment and reference completion of the TS in the clinic notes and place copy in the case notes.
- Provide GP READ codes attached to whichever TS format used or issue to GP practices separately.
- Test for 10 patients and then review the process and amend before implementation.
- Attach the template or prompt list to the front of case notes prior to the patient being seen in clinic.
- Pre-fill the entries where possible (electronically or by hand) such as for common signs and symptoms of recurrence and treatment toxicities.
- For complex tumour groups consider a separate list of signs and symptoms and key contacts may be required.
- If the TS template is set up on a local electronic database, add common side effects, signs and symptoms of recurrence and medications as drop down menus.
- Where possible use the TS available on Infoflex CIMS or Somerset Cancer Register as these will self populate much of the detail.
- Share testing and experience with other colleagues to encourage wider testing and spread of the use of the TS.

Summary of evaluation following testing

The TS has been positively received in both primary and secondary care. 80% of GPs found the summary useful or very useful. Over 50% felt it would make a difference to the way they managed patients and 90% wanted its use to continue. The majority of hospital clinicians recognised the value of summarising what could be months of treatment and holistic care into a concise summary. One clinician felt that *'it made us document and communicate better'* another thought it to be *'excellent'.*

Patients found it useful to share with family/carers, if they were admitted in an emergency to another hospital or hospice and when applying for travel insurance as the TS kept all the necessary information in one place.

Further information and reports available on the National Cancer Survivorship Initiative website at http://www.ncsi.org.uk/what-we-are-doing/assessment-care-planning/treatment-summary/

or contact: Dr Rosie Loftus – GP Macmillan Lead rloftus@macmillan.org.uk or Noeline Young nyoung@macmillan.nhs.uk

Treatment Summary **Appendix 1**

Insert GP Contact Details ***Insert Trust Logo***
Address

Dear Dr X

Re: Add in patient name, address, date of birth and record number

Your patient has now completed their initial treatment for cancer and a summary of their diagnosis, treatment and ongoing management plan are outlined below. The patient has a copy of this summary.

<table>
<tr><td>Diagnosis:</td><td>Date of Diagnosis:</td><td>Organ/Staging

Local/Distant</td></tr>
<tr><td colspan="2">Summary of Treatment and relevant dates:</td><td>Treatment Aim:</td></tr>
<tr><td colspan="2" rowspan="2">Possible treatment toxicities and / or late effects:</td><td>Advise entry onto primary care palliative or supportive care register

Yes / No</td></tr>
<tr><td>DS 1500 application completed

Yes/No

Prescription Charge exemption arranged

Yes/No</td></tr>
<tr><td colspan="2">Alert Symptoms that require referral back to specialist team:</td><td>Contacts for re referrals or queries:

In Hours:

Out of hours:</td></tr>
<tr><td colspan="2">Secondary Care Ongoing Management Plan: (tests, appointments etc)

.</td><td rowspan="2">Other service referrals made: (delete or add)
District Nurse
AHP
Social Worker
Dietician
Clinical Nurse Specialist
Psychologist
Benefits/Advice Service
Other</td></tr>
<tr><td colspan="3">Required GP actions in addition to GP Cancer Care Review (e.g. ongoing medication, osteoporosis and cardiac screening)</td></tr>
<tr><td colspan="3">Summary of information given to the patient about their cancer and future progress:</td></tr>
<tr><td colspan="3">Additional information including issues relating to lifestyle and support needs:</td></tr>
</table>

Completing Clinician: **Signature:** **Date:**

GP READ CODES FOR COMMON CANCERS (For GP Use only). Other codes available if required. (Note: System codes are case sensitive so always ensure codes are transcribed exactly as below)

(October 2010 release).

System 1	**(5 digit codes)**	**All other systems**	**Version 3 five byte codes**
Diagnosis:		**Diagnosis**	
Lung Malignant Tumour	XaOKG	Malignant neoplasm of bronchus or lung	B22z.
Carcinoma of Prostate	X78Y6	Malignant neoplasm of prostate	B46..
Malignant tumour of rectum	XE1vW	Malignant neoplasm of Rectum	B141.
Bowel Intestine	X78gK	Malignant neoplasm of Colon	B13..
Large Bowel	X78gN	Malignant neoplasm of female breast	B34..
Female Malignant Neoplasia	B34..	Malignant neoplasm of male breast	B35..
Male Malignant Neoplasia	B35..		
Histology/Staging/Grade:		**Histology/Staging/Grade:**	
Histology Abnormal	4K14.	Histology Abnormal	4K14.
Tumour grade	X7A6m	Tumour staging	4M…
Dukes/Gleason tumour stage	XaOLF	Gleason grading of prostate Ca	4M0..
Recurrent tumour	XaOR3	Recurrence of tumour	4M6..
Local Tumour Spread	X7818		
Mets from 1°	XaFr.	Metastatic NOS	BB13.
Treatment		**Treatment**	
Palliative Radiotherapy	5149.	Radiotherapy tumour palliation	5149.
Curative Radiotherapy	XalpH	Radiotherapy	7M371
Chemotherapy	x71bL	Chemotherapy	8BAD.
Radiotherapy	Xa851		
Treatment Aim:		**Treatment Aim:**	
Curative procedure	Xallm	Curative treatment	8BJ0.
Palliative procedure	XaiL3	Palliative treatment	8BJ1.
Treatment toxicities/late effects:			
Osteoporotic #	Xa1TO	At risk of osteoporosis	1409.
Osteoporosis	XaELC	Osteoporosis	N330.
Infection	Xa9ua		
Ongoing Management Plan		**Ongoing Management Plan**	
Follow up arranged (<1yr)	8H8..	Follow up arranged	8H8..
Follow up arranged (>1yr)	XaL..		
No FU	8HA1.	No follow up arranged	8HA..

Referral PRN	8HAZ.		
Referrals made to other services:		**Referrals made to other services:**	
District Nurse	XaBsn	Refer to District Nurse	8H72.
Social Worker	XaBsr	Refer to Social Worker	8H75.
Nurse Specialist	XaAgq		
SALT	XaBT6		
Actions required by the GP		**Actions required by the GP**	
Tumour marker monitoring	Xalqg	Tumour marker monitoring	8A9..
PSA	Xalqh	PSA	43Z2.
Osteoporosis monitoring	XalSd	Osteoporosis monitoring	66a..
Referral for specialist opinion	Xalst		
Advised to apply for free prescriptions	9D05	Entitled to free prescription	6616.
Cancer Care Review	Xalyc	Cancer Care Review	8BAV.
Palliative Care Review	XalG1	Palliative Care Plan Review	8CM3.
Medication:		**Medication:**	
New medication started by specialist	XEOhn	Medication given	8BC2.
Medication changed by specialist	8B316	Medication changed	8B316
Advice to GP to start medication	XaKbF		
Advice to GP to stop medication	XaJC2		
Information to patient:		**Information to patient:**	
DS1500 form claim	XaCDx	DS1500 completed	9EB5.
Benefits counselling	6743.	Benefits counselling	6743.
Cancer information offered	XalmL	Cancer information offered	677H.
Cancer diagnosis discussed	XalpL	Cancer diagnosis discussed	8CL0.
Aware of diagnosis	XaQly		
Unaware of prognosis	XaVzE		
Carer aware of diagnosis	XaVzA		
Miscellaneous:		**Miscellaneous:**	
On GSF palliative care framework	XaJv2	On GSF Palliative Care Framework	8CM1.
GP OOH service notified	Xaltp	GP OOH service notified	9e0..
Carers details	9180.	Carer details	9180.

Appendix 2

Template in letter format

Date: XXXXXXXX

Dear Dr *Enter GP name XXXX*

Re: patients' name

Your patient has now completed their initial treatment for cancer and a summary of their diagnosis; treatment and ongoing management plan are outlined below. The patient has a copy of this summary.

Diagnosis:

Date of diagnosis:

Staging:

Summary of treatment and relevant dates:

Treatment Aim:

Possible treatment toxicities and / or late effects:

Alert symptoms that require referral back to specialist team:

Secondary Care Ongoing Management Plan: (tests, appointments)

Required GP actions: (e.g. Medication, osteoporosis/cardiac screening)

Summary of information given to the patient and/or their carer:

Additional information including issues related to lifestyle and support needs:

Advise entry onto primary care palliative or supportive care register: (Yes/No)

DS1500 application completed: (Yes/No/N/A)

Prescription charge exemption arranged: (yes or No)

Contact for re-referral or any queries;

In hours

Out of hours:

Yours sincerely

Clinician xxxxxxxx

CC: *Insert patient name*

Treatment Summary Example **Appendix 3**

Dear Dr Jones

Re: John Smith, 3 Park Road, Doncaster DN4 DEF DoB: 10.10.10 NHS No: 123456

Your patient has now completed their initial treatment for cancer and a summary of their diagnosis; treatment and ongoing management plan are outlined below. The patient has a copy of this summary.

<table>
<tr><td>Diagnosis:

Colorectal Cancer</td><td>Date of Diagnosis:

10.02.10</td><td>Organ/Staging – Dukes T2

Local/Distant – N0</td></tr>
<tr><td colspan="2">Summary of Treatment and relevant dates:

Surgery – Resection (March 10) and reversal of stoma (Sept 10)
Radiotherapy - May – June 2010</td><td>Treatment Aim:

Curative</td></tr>
<tr><td colspan="2" rowspan="2">Possible treatment toxicities and / or late effects:

Diarrhoea following pelvic radiotherapy

.</td><td>Advise entry onto primary care palliative or supportive care register

No</td></tr>
<tr><td>DS1500 application completed - No

Prescription Charge exemption arranged - Yes</td></tr>
<tr><td colspan="2">Alert Symptoms that require referral back to specialist team:

• Diarrhoea for more than 2 weeks not relieved by loperamide/codeine
• Blood or mucus per rectum
• Further change in bowel function
• Abdominal pain that persists for longer than 4 weeks and does not respond to simple analgesia</td><td>Contacts for re referrals or queries:

In Hours: 01234 567890 (CNS team)

Out of hours: 01234 987654 (oncology ward)</td></tr>
<tr><td colspan="2">Secondary Care Ongoing Management Plan: (tests, appointments etc)

• Next OP Review - Jan 2011
• CEA next due in Jan 2011 then annually until 2015
• CT scan (abdo and chest) next due Sept 2011
• Colonoscopy repeat next due Sept 2015</td><td>Referrals made to other services:

Community Dietician
Benefits/Advice Service</td></tr>
<tr><td colspan="3">Required GP actions e.g. ongoing medication, osteoporosis and cardiac screening

Please review dose of XXXXX in two months if symptoms of XXXX resolved reduce to 4mg daily
Cancer Care Review within 3 months</td></tr>
<tr><td colspan="3">Summary of information to the patient and/or their carer:

Patient and wife informed that the cancer in his colon was non invasive and that he has received surgery and radiotherapy with curative intent. He is aware however that it may recur in the future and we have briefly discussed the further treatment available should this be required. He is fully aware of the symptoms of recurrence and what to do should any occur.</td></tr>
<tr><td colspan="3">Additional information relating to lifestyle and support needs

Patient advised to quit smoking and referred to smoking cessation clinic
Patient keen to join local colorectal support group and plans to attend next session in November</td></tr>
</table>

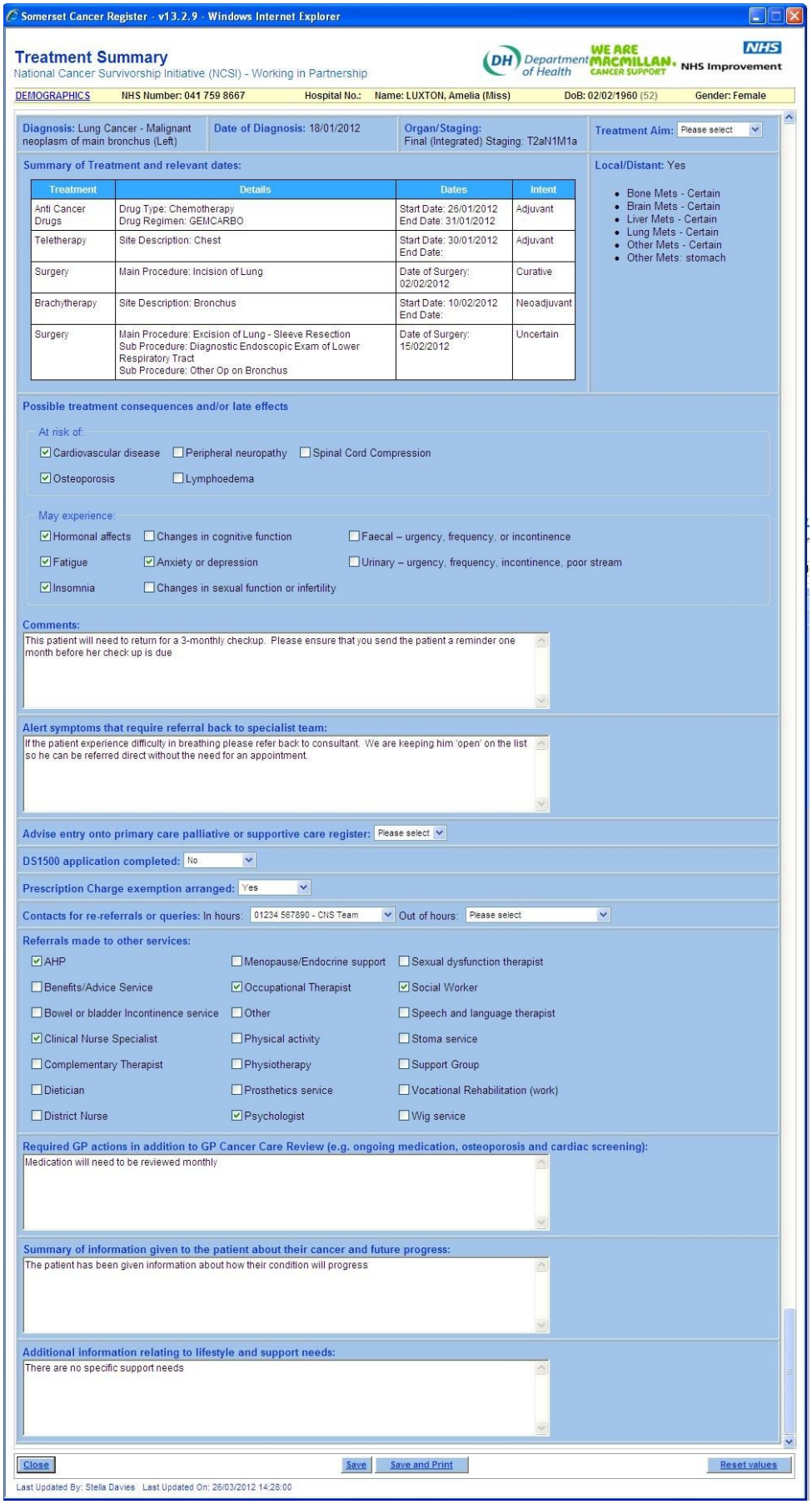
Completing Clinician: Charles Goodenough **Signature:**

Date: 30.10.10

Appendix 4

Screen Shot from

Somerset Cancer Register



Somerset Cancer Register - v13.2.9 - Windows Internet Explorer

Treatment Summary

National Cancer Survivorship Initiative (NCSI) - Working in Partnership

DH Department of Health | WE ARE MACMILLAN. CANCER SUPPORT | NHS Improvement

DEMOGRAPHICS | NHS Number: 041 759 8667 | Hospital No.: | Name: LUXTON, Amelia (Miss) | DoB: 02/02/1960 (52) | Gender: Female

Diagnosis: Lung Cancer - Malignant neoplasm of main bronchus (Left)

Date of Diagnosis: 18/01/2012

Organ/Staging: Final (Integrated) Staging: T2aN1M1a

Treatment Aim: Please select

Summary of Treatment and relevant dates:

Treatment	Details	Dates	Intent
Anti Cancer Drugs	Drug Type: Chemotherapy Drug Regimen: GEMCARBO	Start Date: 26/01/2012 End Date: 31/01/2012	Adjuvant
Teletherapy	Site Description: Chest	Start Date: 30/01/2012 End Date:	Adjuvant
Surgery	Main Procedure: Incision of Lung	Date of Surgery: 02/02/2012	Curative
Brachytherapy	Site Description: Bronchus	Start Date: 10/02/2012 End Date:	Neoadjuvant
Surgery	Main Procedure: Excision of Lung - Sleeve Resection Sub Procedure: Diagnostic Endoscopic Exam of Lower Respiratory Tract Sub Procedure: Other Op on Bronchus	Date of Surgery: 15/02/2012	Uncertain

Local/Distant: Yes

- Bone Mets - Certain
- Brain Mets - Certain
- Liver Mets - Certain
- Lung Mets - Certain
- Other Mets - Certain
- Other Mets: stomach

Possible treatment consequences and/or late effects

At risk of:

☑ Cardiovascular disease ☐ Peripheral neuropathy ☐ Spinal Cord Compression

☑ Osteoporosis ☐ Lymphoedema

May experience:

☑ Hormonal affects ☐ Changes in cognitive function ☐ Faecal – urgency, frequency, or incontinence

☑ Fatigue ☑ Anxiety or depression ☐ Urinary – urgency, frequency, incontinence, poor stream

☑ Insomnia ☐ Changes in sexual function or infertility

Comments:

This patient will need to return for a 3-monthly checkup. Please ensure that you send the patient a reminder one month before her check up is due

Alert symptoms that require referral back to specialist team:

If the patient experience difficulty in breathing please refer back to consultant. We are keeping him 'open' on the list so he can be referred direct without the need for an appointment.

Advise entry onto primary care palliative or supportive care register: Please select

DS1500 application completed: No

Prescription Charge exemption arranged: Yes

Contacts for re-referrals or queries: In hours: 01234 567890 - CNS Team Out of hours: Please select

Referrals made to other services:

☑ AHP	☐ Menopause/Endocrine support	☐ Sexual dysfunction therapist
☐ Benefits/Advice Service	☑ Occupational Therapist	☑ Social Worker
☐ Bowel or bladder Incontinence service	☐ Other	☐ Speech and language therapist
☑ Clinical Nurse Specialist	☐ Physical activity	☐ Stoma service
☐ Complementary Therapist	☐ Physiotherapy	☐ Support Group
☐ Dietician	☐ Prosthetics service	☐ Vocational Rehabilitation (work)
☐ District Nurse	☑ Psychologist	☐ Wig service

Required GP actions in addition to GP Cancer Care Review (e.g. ongoing medication, osteoporosis and cardiac screening):

Medication will need to be reviewed monthly

Summary of information given to the patient about their cancer and future progress:

The patient has been given information about how their condition will progress

Additional information relating to lifestyle and support needs:

There are no specific support needs

Close | Save | Save and Print | Reset values

Last Updated By: Stella Davies Last Updated On: 26/03/2012 14:28:00

Appendix 5

Rationale for data fields and inclusion on the Treatment Summary

Field	Rationale for inclusion	Essential or Desirable
Diagnosis	Important for the GP and patient to know type of cancer and location of cancer and the likely source of secondary recurrence.	E
Organ Staging/local or distant spread (Grade)	Information about staging and spread provides insight into prognosis and risk of recurrence	D
Date of Diagnosis	To understand length of time patient has known diagnosis and time period between referral from primary care and diagnosis to identify where delays can be minimised in future. Important data to monitor treatment outcomes in relation to survivorship. Helps plan date of GP Cancer Care Review.	E
Summary of Treatment and relevant dates	To understand the range and order of modality treatment, understand the likely sequence of treatment effects. Essential to inform future treatment choice if further disease occurs. Important information for patients wishing to take out insurance or a mortgage.	E
Treatment Aim	To understand whether treatment intended is curative, palliative or for symptom relief as this will help GPs to understand aims of treatment and to refer back to secondary care or other services appropriately. Also supports GPs to anticipate future care needs.	E
Possible treatment toxicities and or late effects of treatment	Patients undergoing some cancer treatments may be more prone to toxicity and late effects of treatment such as osteoporosis or heart disease. Inclusion of risks in this summary triggers the entering of the patient onto routine GP surveillance (QOF related). Signs and symptoms addressed earlier may improve quality of life and treatment outcomes from side effects or late consequences of treatment. Inclusion of suggested or preferred treatment associated with toxicities and late effects can be initiated without referral back to the specialist. Raises awareness of common late effects and reduces delays to further investigation and treatment. This may also impact on survival rates as symptoms are picked up sooner	E
Advise entry onto palliative or supportive care register	Inclusion of the patient on the palliative care register ensures that the out of hours(OOH) teams are made aware that a patient is nearing end of life and that increased input maybe required to support patient and carers. Register is shared with all relevant OOH doctors, ambulance service, community district nursing teams, Macmillan support team, social care, hospice as appropriate. Patients can then receive the appropriate support, information and benefits.	E
Key contact in hours for advice and re-access	To ensure the patient, GPs and primary care team know who and when to contact should they have queries or concerns. The contact should be able to triage enquiries and initiate action	E
DS 1500 status (benefit that patient can claim at the last 6 months of life)	If no DS 1500 completed the GP will be prompted to arrange.	E
Prescription exemption	If no prescription exemption completed the GP will be prompted to arrange. Exemption charges are waived for any cancer treatment - an entitlement for all patients with a diagnosis of cancer. Applies to any drug that the cancer patient may require.	E
Alert symptoms that require referral	This should include only those symptoms where immediate	E

back to specialist team	re-referral to secondary care specialist is required e.g. acute breathlessness requiring a pleural tap, as opposed to the expected side effects of treatment that can be managed by the GP or community team. Patients will have a better understanding about symptoms that they should be concerned about and should prompt contact with the specialist team.	
Contact for re referrals or queries in and out of hours	Confirms contact details for the patient or GP for advice on care or treatment or to arrange urgent review. The out of hours contact could be a ward, the acute oncology team or relevant on call team	E
Secondary Care On-going Management plan	Include any planned outpatient reviews and surveillance tests dates (or approximated timescales). This provides a framework for GPs. If indicated, further tests can be scheduled prior to the further outpatient visits. The Patient will be better informed about follow up plans and what to expect. It is reassuring to patients and carers to see the planned care, surveillance and support, they then know what to expect and when.	E
Referrals to other services	Helps avoid duplication of referral if the patient visits the GP between appointments and is unsure of who is involved in their care. Particularly useful in respect of social care referrals and whether the patient is known to other agencies. Can help to reinforce the importance of attending appointments with other agencies. Useful to also include details related to third sector support and centres such as a Maggie's centre if available.	D
Required GP actions including medication etc	To provide clarity on the expectation of GPs in respect of the patients on-going care and how they can support them. Also provides prompts e.g. to add patients to routine screening programmes to help mitigate late effects of treatment. Patients will be more empowered to approach GPs if they require further advice and support. Can give specific request to GPs to ensure continuity of care and avoid ambiguity. Provides GPs with guidance and advice on which drugs if any need stopping and when and whether any adjusting between follow up appointments or following discharge. May avoid inappropriate prescriptions, overdose or misuse. Particularly important if the GP is going to continue to prescribe long term i.e. endocrine manipulation. Patients will also know what to expect from GP.	E
Cancer Care Register	Inclusion of this reminder helps ensure the patient is entered onto the register and that they are formally reviewed by the GP within 6 months of diagnosis. This is a requirement for the Quality Outcome Framework within all general practices	D
Summary of information provided to patient on diagnosis and prognosis	Sharing information on what has been discussed with the patient and their carer and any written information provided, improves the quality and openness of the discussion that the GP can have with the patient	E
Additional Information to the patients and/or their carer	To confirm which lifestyle information and advice has been given or signposted and details of local support groups and psychosocial support, complementary therapies, returning to work advice etc	D
READ Codes Include a copy of the READ codes with the Treatment Summary. You may chose to send local GP practices a laminated copy of the READ Codes in advance to save sending each time.	It is the responsibility of the GPs to assign the appropriate codes and enter on their systems. GP READ codes are similar to hospital HRG codes and used to identify diagnosis, tests and treatments. Both are complex systems and require manual input. Inclusion of the READ codes in the TS prompts and encourages GPs to accurately code patients. This helps improve patient safety in terms of surveillance, disease tracking and audit. Note Codes may differ depending on GP IT system in use	D

Disclaimer
We have made every effort to ensure that the information we have provided is accurate and will help you to introduce the Treatment Summary into the care and support that you provide. The National Cancer Survivorship Initiative (NCSI) cannot accept liability for from any inaccuracy in this information or third party information such as information on websites to which we link.

Thanks
This booklet has been written, revised and edited by the NCSI Treatment Summary steering group which includes Macmillan Cancer Support General Practitioner Advisors.
We acknowledge and thank NHS Improvement, the National Leads and Test Sites for their work in developing and testing the Treatment Summary and to Tribal Consulting Limited for evaluating the work of the test sites.

We also thank the Somerset Cancer Register and Infoflex CIMS for their work in transforming this concept into an electronic solution.